

PRA Medical/Social History Form

Directions: Please answer the following questions to the best of your knowledge.

Your records are considered confidential. Your records will not be released to any party without your written consent.

PATIENT INFORMATION				
Last Name	First Name	Middle	Birthdate	
Home/Cell Phone	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SPIRITUAL/CULTURAL ISSUES

Religion: _____ Does your religion play a significant supportive role in your life? Circle: YES NO

PRIMARY PHYSICIAN(S)		
Name	Address	Phone:

Last time you visited your primary physician: _____ Reason for visit: _____

Medication Allergies? Yes No Substance or Food Allergies? Yes No

If yes, what medication(s) _____ If yes, what substance(s) _____

Current Height: _____ Current Weight: _____ (Please give best estimate)

Would you like your PRA Clinician to communicate with your Primary Care Provider (PCP) Yes No

FAMILY HISTORY: Please if your family has a history of:

- Diabetes High Blood Pressure Heart Attack, Heart Disease Blood Clots or Stroke Tuberculosis
 Cancer Alzheimer's Family History Unknown Epilepsy/Seizure Thyroid/Other Endocrine Conditions
 Mental Illness...be specific below...If you answered Yes to any of the above, please explain: _____

MEDICATIONS (INCLUDE OVER THE COUNTER MEDICATIONS) Continue on back of page if more space is needed

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (list over the counter medications, sedatives, pain medications, sleeping pills, antidepressants, etc)

Social Risk History

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many cigarettes per day? Would you like information on smoking cessation? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you ever smoke? If yes, when did you stop?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use alcohol? If yes, how often, how much?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had or would you like help now with an alcohol or drug problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use Herbal Supplements? If yes, what kinds, for what purpose, how much and how often?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink caffeinated beverages? If yes, what beverages and how often?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you vape? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long have you been vaping? _____ How often do you vape? _____

Please explain any yes responses: _____

REVIEW OF SYSTEMS: Please if you currently have or have ever had the following

I. Constitutional:

- | | | | |
|---|--|---|--|
| Lasting cough | <input type="checkbox"/> Current <input type="checkbox"/> Past | Unusual discharge (vaginal or from penis) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Chronic Fatigue | <input type="checkbox"/> Current <input type="checkbox"/> Past | Changes in Appetite | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Shortness of breath | <input type="checkbox"/> Current <input type="checkbox"/> Past | Persistent weight loss without dieting | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Chest pain | <input type="checkbox"/> Current <input type="checkbox"/> Past | Weight problem/eating disorder | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Recurrent night sweats, chills, fevers | <input type="checkbox"/> Current <input type="checkbox"/> Past | Hepatitis | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Swollen glands (neck, armpits or groin) | <input type="checkbox"/> Current <input type="checkbox"/> Past | Other: _____ | <input type="checkbox"/> Current <input type="checkbox"/> Past |

Tuberculosis: Ever Tested? Yes No Date and result of last test: _____ If Positive, did you have a chest x-ray? _____
 Ever Treated? Yes No Date(s) and type(s) of treatment: _____

PRA Medical/Social History Form

Directions: Please answer the following questions to the best of your knowledge.

Your records are considered confidential. Your records will not be released to any party without your written consent.

REVIEW OF SYSTEMS CONTINUED.... Please if you currently have or have ever had the following

2. Skin Conditions

- Allergies/Rash/Itching Current Past
- Severe Dry Skin Current Past

3. Eyes

- Vision problems Current Past
- Glaucoma Current Past

4. Endocrine

- Fatigue Current Past
- Weight gain/loss Current Past
- Headaches Current Past
- Excessive Thirst Current Past
- Grave's Disease/Thyroid Conditions Current Past
- Diabetes's Current Past

5. Ears, Nose, Throat

- Hearing problems Current Past
- Teeth/gum problems or disease Current Past
- Frequent nosebleeds Current Past
- Recurrent sinusitis Current Past
- Frequent sore throats Current Past

6. Cardiac

- Palpitations/arrhythmia Current Past
- Heart disease/murmur Current Past
- High blood pressure / Low blood pressure Current Past
- High cholesterol Current Past
- Thrombophlebitis/blood clots Current Past

7. Neurologic

- Stroke Current Past
- Dizziness/confusion/wandering Current Past
- Forgetfulness/memory lapse/memory loss Current Past
- Migraines Current Past
- Multiple Sclerosis Current Past

8. Psychiatric

- Problems with Concentration Current Past
- Persistent Worries Current Past
- Prolonged Periods of Sadness Current Past
- Paranoid Thoughts Current Past
- Hallucinations Current Past
- Insomnia Current Past
- Mood Instability Current Past
- Panic Attacks Current Past

9. Gastrointestinal

- Recurrent nausea/vomiting/diarrhea Current Past
- Constipation Current Past
- Stomach/bowel problems Current Past

10. Respiratory

- Difficulty breathing – cough Current Past
- Asthma – bronchitis Current Past
- Sleep disturbance Current Past

11. Hemalogic/Lymphatic

- Anemia/Blood Disorder Current Past

12. Genitourinary

- Bladder/kidney problems or infection Current Past
- Incontinence (unable to control bladder) Current Past
- Enuresis (bedwetting) Current Past
- Sexually transmitted diseases: Current Past
- Bloody or painful urination Current Past

Females:

- Menstrual Difficulties Current Past
- Cycle: Regular ___ Irregular ___
Pre-Menopause ___ Menopause ___
- Problems/infection of tubes/ovaries/uterus Current Past
- Breast disease / tumor / surgery Current Past

13. Allergic/Immunologic

- Allergies Current Past
- Autoimmune Disorder Current Past

14. Musculoskeletal

- Orthopedic Injuries Current Past
- Muscle Aches Current Past
- Arthritis Current Past

15. Chronic Issues

- Cancer Current Past

Other Conditions or Problems Not Listed:

- Current Past

I certify that I have answered these questions to the best of my knowledge

Patient Signature (if 12 and older) _____ Parent/Guardian Signature: _____ Date: _____

CLINICIANS NOTES – MD TO COMPLETE BELOW

All areas reviewed and no significant medical issues are affecting this patient's psychiatric care.

Reviewed by (Clinician):

Date: